Northwest Neurology

POLICY ACKNOWLEDGEMENTS

_____ I consent to diagnosis, care and treatment that isconsidered necessary or advised by my physicians(s), including my attending physician, other healthcare professionals, their employees and agents,who may be involved in my care. I acknowledge that noguarantees have been made to me regarding the results of my examination or treatment by Northwest Neurology.

_____ As applicable, when my consent is required, I consent to the release all of my health and other information, including sensitive health information, to any private health insurance plan, Medicare, Medicaid, other governmental insurance program, third-party payer, benefits provider or their agents, in order for Northwest Neurology to obtain payment for the treatment and services provided to me. If I do not consent or later revoke this consent, Iunderstand that I will be responsible to pay forany treatments and services that are received.

_____ I authorize Northwest Neurology to access my prescription/medication history in order to safely prescribe medication.

_____ I have reviewed the Notice of Privacy Practices and acknowledge that I understand and agree to this policy. I can receive a copy of the policy upon request.

_____ I have reviewed the Northwest Neurology Financial Policy and acknowledge that I understand and agree to this policy. I can receive a copy of the policy upon request.

I have read and fully agree to each of the statements in this form and sign below as my free and voluntary act.

_____ _____

Signature of Patient or Legally Authorized Representative Date

_____

Printed Name